Print Reset form

A.R.S. § 43-210
APPLICATION FOR CERTIFICATE OF ELIGIBILITY FOR THE HEALTH INSURANCE PREMIUM TAX CREDIT
SMALL BUSINESS ONLY

Please Print

Small Business Applicant Name:
Small Business Applicant Address Number and Street or PO Box:
City: State ZIP Code
Small Business Owner or Contact Person Name(s)
Small Business Owner or Contact Person Applicant Day-Time Phone Number
Length of time Small Business has been in existence
Maximum number of employees at any time during the most recent calendar year (If this # is greater than 25, you are not eligible for a Certificate)
Number of employees seeking Single Coverage
Number of employees seeking Family Coverage

I have completed this application. I declare that to the best of my knowledge and belief, this information is true, correct and complete. I also declare that the above-named Small Business has not provided health insurance to its employees for at least six consecutive months prior to this application.

Signature _____ Date _____

This application should be mailed to the following address:

Georganna Meyer, Chief Economist
Office of Economic Research and Analysis
Arizona Department of Revenue
PO Box 25248
Phoenix, AZ 85002

If you have questions regarding completion of this form, contact Georganna Meyer at (602) 716-6927.